TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
BAYLOR SURGICARE AT PLANO

Respondent Name
ARCH INSURANCE CO

MFDR Tracking Number
M4-16-3523-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JULY 26, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At this time we are requesting that this be claim paid in accordance with the 2015 Texas Workers Comp Fee Schedule and Guidelines."

Amount in Dispute: $2,058.37

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We maintain that no additional is due for this date of service."

Response Submitted By: Broadspire

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 20, 2015	Ambulatory Surgical Care for CPT Code 28730	$0.00	$0.00
	Ambulatory Surgical Care for HCPCS Code L8699	$1,430.66	$0.00
	Interest	$627.71	$0.00
TOTAL		$2,058.37	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. Texas Labor Code 413.011(b) provides for additions or exceptions to the Medicare policies.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
   - C19-Charges for surgical implants are reviewed separately by ForeSight Medical.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - Upon review of submitted request for reconsideration, ForeSight has determined that no additional allowance will be made.
   - Device payment was paid at the geographic Market Comparative Device Rate (MCDR) due to missing or incomplete documentation from this facility.
   - This item was determined to be a supply/non-implantable item.
   - Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.

Issues

Is the requestor entitled to additional reimbursement for HCPCS code L8699?

Findings

HCPCS code L8699 is defined as "Prosthetic implant, not otherwise specified."

The respondent paid $2,536.18 for HCPCS code L8699 based upon a recommendation from ForeSIGHT Medical. The requestor contends that additional reimbursement of $1,430.66 is due per the fee guideline.

The fee guideline for Ambulatory Surgical Care Services is found in 28 Texas Administrative Code §134.402.

28 Texas Administrative Code §134.402(d) states,

> For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section.

28 Texas Administrative Code §134.402(b)(5) states,

> Implantable means an object or device that is surgically:
>
> (A) implanted,
> (B) embedded,
> (C) inserted,
> (D) or otherwise applied, and
> (E) related equipment necessary to operate, program, and recharge the implantable.

The requestor billed HCPCS code L8699 for implantables used for surgery on claimant's left foot.

28 Texas Administrative Code §134.402(f)(1)(B)(i)(ii) states,

> The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures

shall be: (B) if an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the non-device intensive procedure shall be the sum of: (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission; and (ii) the Medicare ASC facility reimbursement amount multiplied by 153 percent.

A review of the submitted documentation finds that the requestor submitted a copy of an invoice from Stryker that lists the total cost of $6,277.10. The requestor did not submit an Implant Record to support the implantables used for the procedure. The respondent paid $2,536.18. Without the Implant Record additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		09/29/2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.